BENEFIT STATEMENT CHANGE FORM

COMMONWEALTH OF MASSACHUSETTS

Your BenefitsConnection
Group Insurance Commission

Complete this form ONLY if you are requesting a change.

Please read the following instructions CAREFULLY to make change(s). Do NOT send the GIC your benefit statement. Place an "X" in the box for each change that applies. NOTE: Failure to notify the GIC of family status changes, such as divorce, remarriage, and/or addition of dependents may result in financial liabilities.

Please include the items listed after **"MUST SEND"**, if applicable. If these items are not included, your request cannot be processed. Be sure to complete and sign in the box below and return to:

Group Insurance Commission, P.O. Box 8747, Boston, MA 02114-8747 • 617.727.2310

PLEASE PRINT AND FILL OUT COMPLETELY.

Name of Insured: _____ GIC ID # *(Social Security #)*: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Signature of Insured: _____ Date: _____

1. ☐ I request a birth date correction for: **MUST SEND:** *Copy of corresponding birth certificate(s)*

☐ Self ☐ Spouse ☐ Dependent(s)

2. ☐ I have been tobacco-free *(have not smoked cigarettes, cigars or pipes nor used snuff or chewing tobacco)* for the past 12 months or longer and wish to participate in the **Optional Life Insurance** non-smoker plan. I understand that this election cannot take effect before July 1, 2004, and that it only applies to Active Employees and State Retirees with **Optional Life Insurance** coverage.

3. ☐ Please change my address to that listed above.

4. ☐ I request to change or correct my life insurance beneficiary designation and have completed the enclosed Beneficiary Designation Form. ***If the Beneficiary Designation Form is not completed the change or correction cannot be made.*** *(This change only applies to insureds who are eligible for life insurance through the GIC.)*

MUST SEND: *Completed Beneficiary Designation Form (enclosed)*

NOTE: Please be sure to fill in the GIC ID# (*usually your Social Security Number)* and your Agency/Division number, which is listed on the top of your Benefit Statement, on the Beneficiary Designation Form.

5. ☐ I wish to add to my family health insurance plan:

☐ Spouse **MUST SEND:** *Copy of certified marriage certificate*

SS#: _____ Spouse's Date of Birth: _____

☐ Dependent(s) **MUST SEND:** *Copy of dependent's birth certificate.*
NOTE: The birth certificate must link either you or your spouse to the dependent.

SS#: _____ Dependent's Date of Birth: _____

6. ☐ I wish to change my marital status from "married" to "divorced".

MUST SEND: *Copy of the following sections of the divorce decree: absolute date, health insurance language, and signature pages.*

My former spouse's current or last known home address is:

Street Address: _____ City: _____ State: _____ Zip: _____

7. ☐ I am divorced and remarried on date: _____

MUST SEND: *Copy of certified marriage certificate*

8. ☐ My former spouse remarried on date: _____

Street Address: _____ City: _____ State: _____ Zip: _____